DOCUMENT RESUME

ED 289 122 CG 020 388

TITLE	Health Care Fraud: Characteristics, Sanctions, and Prevention. Briefing Report to the Honorable William V. Roth, Jr., U.S. Senate.
INSTITUTION	General Accounting Office, Washington, DC. Accounting and Financial Management Div.
REPORT NO	GAO/AFMD-87-29BR
PUB DATE	Jul 87
NOTE	37p.
AVAILABLE FROM	U.S. General Accounting Office, P.O. Box 6015, Gaithersburg, MD 20877 (1-5 copies, free; 6-99 copies, $2.00 each; 25% discount for 100 or more copies).
PUB TYPE	Reports - General (140)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	Court Litigation; *Criminals; *Fines (Penalties); *Government Role; *Health Personnel; *Health Programs
IDENTIFIERS	*Fraud; Medicaid; *Medicare

ABSTRACT

At the request of Senator William Roth, Jr., the General Accounting Office (GAO) reviewed Medicare and Medicaid fraud investigations that agency inspectors general referred to the Department of Justice for prosecution to identify characteristics of alleged fraud against the government and to determine actions taken against those caught defrauding the government. A review of 279 Medicare and Medicaid cases from the Office of Inspector General revealed that 89% of the cases involved submission of false claims; 3% involved kickbacks; and 2% involved perjury, theft, or misuse of government property. About 85% of cases involved health care providers, of which approximately 50% were medical doctors. About 50% of cases involved allegations of fraud committed against the Medicare program, 30% involved Medicaid, and 9% involved more than one health care program. Three types of action which can be taken against health care providers who commit Medicare or Medicaid fraud were identified: (1) subjection to criminal or civil action by the Department of Justice; (2) assessment with a civil monetary penalty; and (3) suspension from participating in the Medicare and Medicaid programs. A review of 351 cases revealed that, in 275 cases, subjects were either prosecuted, fined, or suspended from participation in the program. New procedures are being initiated by the Office of Inspector General to ensure that vulnerabilities in the Medicare and Medicaid programs are communicated to health care program managers so that underlying causes of fraud can be corrected. The GAO will review this system in the future. (NB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

CG

United States General Accounting Office

GAO

Briefing Report to the Honorable William V. Roth, Jr., U.S. Senate

July 1987

HEALTH CARE FRAUD

Characteristics, Sanctions, and Prevention

ED289122

CG 020388

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy

GAO/AFMD-87-29BR

BEST COPY AVAILABLE

GAO

United States
General Accounting Office
Washington, D.C. 20548

Accounting and Financial
Management Division

B-224759

July 15, 1987

The Honorable William V. Roth, Jr.
United States Senate

Dear Senator Roth:

At your request, we initiated a review of fraud investigations that agency inspectors general referred to the Department of Justice for prosecution. As agreed with your office, we conducted detailed reviews at the departments of Health and Human Services (specifically the Medicare and Medicaid programs), Agriculture, Labor, and Defense and the General Services Administration. On July 7, 1987, we briefed your staff on Medicare and Medicaid fraud. This report is a written version of that briefing. We will brief you or your staff on our work at the other agencies at a later date.

The purpose of our review was to identify (1) the characteristics of alleged fraud against the government for those cases referred for prosecution and (2) actions taken against those who have been caught defrauding the government. We also determined whether the Office of Inspector General (OIG) has an adequate process to identify underlying causes of fraudulent activities and to notify program managers of the need for corrective action. In addition, as agreed with your office, we identified actions taken under section 2105 of the Omnibus Budget Reconciliation Act of 1981, commonly referred to as the Civil Monetary Penalties Law (CMPL), which provides for administrative penalties against health care providers who submit fraudulent claims.

To identify the characteristics of alleged fraud against the government, we reviewed information about 279 Medicare and Medicaid cases from the OIG's computerized data base. The 279 cases that we selected for our review were all the cases identified as having been referred from the OIG to the Department of Justice and closed during fiscal years 1984 and 1985. A case is considered closed when the OIG believes all probable actions have been taken. For the

cases of alleged fraud, our review of the OIG data base showed the following:

-- About 89 percent involved submission of false claims; 3 percent involved kickbacks; and 2 percent involved perjury, theft, or misuse of government property. About 6 percent of the cases in the data base did not relate to specific criminal violations.

-- About 85 percent involved health care providers, of which about 50 percent were medical doctors, 18 percent were medical practitioners (such as chiropractors, dentists, optometrists, etc.), 12 percent were companies providing medical supplies or services such as ambulance services, 9 percent were pharmacists, 8 percent were medical facilities such as nursing homes and clinics, and 3 percent were hospitals. The remaining 15 percent of the cases either involved beneficiaries or the type of subject was not identified in the OIG's data base.

-- About 50 percent involved allegations of fraud committed against the Medicare program, 30 percent involved the Medicaid program, and 9 percent involved more than one health care program. For about 11 percent, the program was not identifiable in the data base.

We also found that three types of actions can be taken against health care providers that commit Medicare or Medicaid fraud. The provider can be (1) subjected to criminal or civil action by the Department of Justice, (2) assessed with a civil monetary penalty by the OIG, and/or (3) suspended from participating in the Medicare and Medicaid programs by the OIG. Suspensions are required under 42 U.S.C. 1320a-7(a) if the provider is convicted of Medicare or Medicaid fraud and are authorized under 42 U.S.C. 1320(c) if the Secretary determines that such fraud has occurred but the provider has not been convicted.

To determine what actions were taken against those who were caught committing Medicare and Medicaid fraud, we reviewed the 279 cases which were both referred and closed during fiscal years 1984 and 1985 and 72 additional cases which the OIG considered to have been successfully prosecuted by Justice during that period but referred in prior years. We found that of these 351 cases, the subjects in 275 cases were either prosecuted, fined, or suspended from participation in the program. We also found that more than

one action was taken against the subject in 89 cases. In total, 389 actions were taken, including

-- 150 CMPL fines or settlements resulting in a recovery of almost $3.50 for every $1.00 allegedly overpaid, totaling about $17 million;

-- 114 suspensions from participation in the Medicare and Medicaid programs;[1]

-- 114 criminal convictions and deferred adjudications,[2] including 38 cases resulting in both prison and probation sentences, 34 cases with probation sentences only, 18 cases with prison terms only, 13 other cases where we could not determine the sentence because the information was missing from the OIG's data base, and 11 cases in which the subjects were neither sentenced to prison nor probation; and

-- 11 pretrial diversions, whereby the subject and a prosecutor signed an agreement that diverts the subject from traditional criminal justice processing into a program of supervision or other services. If the subject successfully completes the established requirements, prosecution is declined. However, if the offender does not successfully comply with the requirements, prosecution can be initiated.

During the course of our review, we identified nine closed cases, about 3 percent of those cases we reviewed, in which OIG officials decided to initiate a suspension or CMPL action after we brought those cases to their attention. Four cases involved providers convicted of Medicare or Medicaid violations but not suspended as required by law.

---

[1]During fiscal years 1984 and 1985, there were a total of 717 suspensions and exclusions from participation in these programs. The majority were not included in our review since the suspension or exclusion occurred because a provider was either convicted by a federal court prior to our study period, convicted by a state court, or not referred to Justice for prosecution.

[2]In a deferred adjudication, the court does not enter a guilty judgment on the subject's plea, but instead places the subject on probation.

In one of those cases, the OIG overlooked the required suspension of a health care provider convicted in 1983 of fraudulently obtaining about $120,000, thus affording a convicted provider the opportunity to continue submitting claims. The remaining five cases involved providers that the OIG had not taken any action against during our study period. After we brought these cases to the attention of OIG officials, they initiated appropriate suspension and/or CMPL actions against these providers. To prevent similar oversights in the future, OIG officials have instituted a new procedure requiring that a high-level OIG official review all cases before they are closed to ensure that all appropriate actions are taken. We believe that such a thorough high-level review of all cases prior to their closure will help prevent similar oversights in the future. We plan to monitor the OIG's new procedure during our ongoing quality assessment review, which is designed primarily to evaluate whether OIG audits and investigations satisfactorily comply with professional standards.

As part of its efforts to determine the underlying causes of fraud, the OIG has established a Management Implication Report (MIR) system to notify program managers of the causes of fraud and to recommend ways to prevent future fraud. During fiscal years 1984 and 1985, the OIG's investigative staff generated 78 MIRs that identified vulnerabilities in the Medicare and Medicaid programs. However, we found there often was no assurance that vulnerabilities had been communicated to program managers so that underlying causes of fraud could be corrected and future occurrences prevented.

The Deputy Assistant Inspector General for Analysis and Inspections acknowledged that his office had not been effective in notifying health care program managers of these identified vulnerabilities. He told us that new procedures are being implemented to ensure that these vulnerabilities are communicated, so that underlying causes of fraud can be corrected. According to draft instructions, a system will be instituted that tracks all MIRs and will serve the purpose of assuring that each MIR is processed through the appropriate steps to conclusion. We plan to review this system in more detail during our OIG quality assessment review and determine the need, if any, for additional action.

AGENCY COMMENTS

We obtained official oral comments from the Inspector General, Department of Health and Human Services, on June 12, 1987. He agreed with our findings but provided some clarifications which we have included in the report where appropriate.

We would be pleased to discuss this information with you at your convenience. Unless you publicly announce its contents earlier, we will not distribute copies of this report until 30 days from the date it is issued. At that time, we will send copies to the Director, Office of Management and Budget; the Secretary, Department of Health and Human Services; and interested congressional committees. We will also send copies to other interested parties, including all federal agencies that were given authorities similar to the Civil Monetary Penalties Law under the Program Fraud Civil Remedies Act of 1986. Copies will be made available to others on request. If you or members of your staff have any questions about the results of our work, please call me at 275-9359.

Sincerely yours,

John J. Adair

John J. Adair
Associate Director

Contents

		Page
APPENDIX		
I	HEALTH CARE FRAUD: CHARACTERISTICS, SANCTIONS, AND PREVENTION	8
	Introduction and Background	8
	Objectives, Scope, and Methodology	8
	Characteristics of Medicare and Medicaid Fraud Cases Referred to the Department of Justice	11
	Actions Taken Against Those Who Committed Medicare and Medicaid Fraud	15
	Inspector General Efforts To Determine the Underlying Causes of Medicare and Medicaid Fraud and Recommend Corrective Action	31
FIGURES		
I.1	Types of Health Care Fraud Referred to Justice, Fiscal Years 1984 and 1985	11
I.2	Types of Health Care Providers Investigated and Referred for Prosecution, Fiscal Years 1984 and 1985	13
I.3	Closed Health Care Fraud Cases Referred to Justice, by Health Care Program, Fiscal Years 1984 and 1985	14
I.4	Civil Monetary Penalties Law Cases, Types of Actions Taken, Fiscal Years 1984 and 1985	21
TABLES		
I.1	Civil Monetary Penalties Law Fines and Settlements, Fiscal Years 1984 and 1985	19

I.2	Fraudulent Overpayments Made in Cases Using the Civil Monetary Penalties Law, Fiscal Years 1984 and 1985	19
I.3	Health Care Fraud Prison Sentences, Fiscal Years 1984 and 1985	24
I.4	Health Care Fraud: Percent of Prison Sentences Suspended, Fiscal Years 1984 and 1985	25
I.5	Health Care Fraud Probation Sentences, Fiscal Years 1984 and 1985	26
I.6	Monetary Assessments on Health Care Cases Accepted for Prosecution, Fiscal Years 1984 and 1985	27

ABBREVIATIONS

CMPL	Civil Monetary Penalties Law
HHS	Department of Health and Human Services
IG	inspector general
MIR	Management Implication Report
OAI	Office of Analysis and Inspection
OIG	Office of Inspector General

HEALTH CARE FRAUD: CHARACTERISTICS, SANCTIONS, AND PREVENTION

INTRODUCTION AND BACKGROUND

On July 17, 1985, you requested that we conduct a governmentwide review of fraud investigations that statutory inspectors general referred to the Department of Justice for prosecution. Specifically, we were asked to analyze fraud investigations referred by the inspectors general at the departments of Agriculture, Defense, and Labor, the General Services Administration, and at the Department of Health and Human Services (HHS) for those cases involving the Medicare and Medicaid programs. This briefing report responds to your request that we review Medicare and Medicaid fraud investigations that the HHS inspector general (IG) referred to Justice for prosecution. We will brief you or your staff on our work at the other agencies at a later date.

HHS's Health Care Financing Administration oversees the Medicare and Medicaid programs. Medicare is a health insurance program covering almost all persons 65 years of age and older and some disabled persons. The federally funded Medicare program consists of two parts, designated A and B. Part A is a hospital insurance program that helps pay for inpatient hospital care and posthospital care in skilled nursing facilities, as well as care in the patient's home and in hospices. Part B is a supplemental medical insurance program that provides funds for physician services, outpatient hospital services, and a variety of other outpatient services. Medicaid is a joint federal and state funded health care program, providing funds for physicians, hospitals, and a wide range of other services for persons unable to pay for such care.

According to the Budget of the United States Government, fiscal year 1985 federal funding for the Medicare and Medicaid programs totaled about $94 billion. Medicare Part A payments totaled about $48.7 billion and accounted for about 52 percent of HHS's Medicare and Medicaid funding. Medicare Part B and the federal portion of the Medicaid payments totaled about $22.7 billion and $22.6 billion, respectively, and each accounted for about 24 percent of the department's Medicare and Medicaid funding.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of this review were to identify (1) the characteristics of alleged health care fraud against the government for those cases referred for prosecution and (2) the actions taken

against those who have been caught defrauding the government. We also assessed whether the Office of Inspector General (OIG) has an adequate process to identify underlying causes of fraudulent activities and to notify program managers of the need for corrective action. In addition, as agreed with your office, we identified actions taken under section 2105 of the Omnibus Budget Reconciliation Act of 1981, commonly referred to as the Civil Monetary Penalties Law (CMPL), which, among other things, provides for administrative penalties against health care providers who submit fraudulent claims. To facilitate our review, we obtained copies of the OIG's Medicare and Medicaid fraud data bases compiled from the investigative case files and entered the information into our computers.

To analyze the characteristics of health care fraud cases, we used these data bases to review the 279 Medicare and Medicaid fraud cases that the OIG referred to Justice and closed during fiscal years 1984 and 1985. These cases were ones that the OIG decided had sufficient evidence of fraud to warrant a U.S. attorney's determination to prosecute. However, some of the cases were declined for prosecution for reasons that we discuss in more detail later in the report. We believe this set of cases was the most reliable and readily available group to use in our analysis of fraud characteristics. We analyzed these cases to determine (1) the programs affected by alleged fraud, (2) the types of alleged fraud that occurred, (3) the individuals investigated for committing the alleged fraud, and (4) the types of actions taken against them.

In order to determine the actions taken against those caught defrauding health care programs, we identified the outcome of the above 279 cases, as well as the outcome in an additional 72 cases that had been referred prior to fiscal year 1984 and considered by the OIG to have been successfully prosecuted by Justice during fiscal years 1984 and 1985. These 351 cases include all cases in which there were sentences, fines, suspensions, and other actions taken against those who were investigated and referred to Justice for prosecution. We analyzed these 351 cases to determine (1) the outcome of prosecutions obtained by Justice in terms of sentences, fines, and penalties levied, (2) CMPL fines and settlements obtained by the OIG, and (3) program suspensions that were imposed on these health care providers.

Of the 351 cases, we reviewed the OIG's files on all 150[3] cases involving a CMPL fine or settlement to assess the application of the law. For the remaining 201 cases, we reviewed the OIG's files on 125 cases to either assess the types of actions taken or determine why no action was taken. The case files contained such information as the outcome of the prosecution, prison and probation sentences, and the amount of the monetary assessments. We compared the information in the data bases with information documented in investigative case files for these 275 of the 351 cases. We did not review the case files for the remaining 76 cases because they involved health care providers against which multiple actions were taken, health care beneficiaries, or unsubstantiated health care fraud. We corrected the computerized information when the data base was inconsistent with information in the case files. In our judgment, the frequency of the inconsistencies between the data base and the case files would not impair the reliability of information we used from the data bases.

We held discussions with OIG, HHS Office of General Counsel, and Justice Department officials to (1) clarify information contained in the data bases and the case files, (2) determine the types of actions that can be taken against perpetrators of health care fraud, (3) obtain explanations for why actions were or were not taken against the subjects in certain cases, and (4) identify how the CMPL has been used to supplement and/or complement the judicial outcome of health care fraud cases.

To determine whether the OIG had an adequate process to identify the underlying causes of fraud and to notify program managers of the recommendations, we reviewed the OIG's guidance and requirements for investigators, identified the mechanisms used to notify program managers of the causes of fraud, and determined whether recommendations were communicated to the program managers. We also evaluated the adequacy of follow-up procedures that the OIG uses to determine whether these recommendations have been implemented.

---

[3]Some of the cases in our sample involve CMPL settlements between individuals and HHS on false claims occurring prior to passage of the CMPL in 1981. The United States Court of Appeals for the Fifth Circuit vacated a 1985 order by an administrative law judge imposing a CMPL fine for false claims submitted in 1979. The court concluded that the CMPL cannot be applied retroactively. Griffon v. United States Department of Health and Human Services, No. 85-4733 (5th Cir. filed October 14, 1986). We did not attempt to evaluate whether the decision has any effect on other cases.

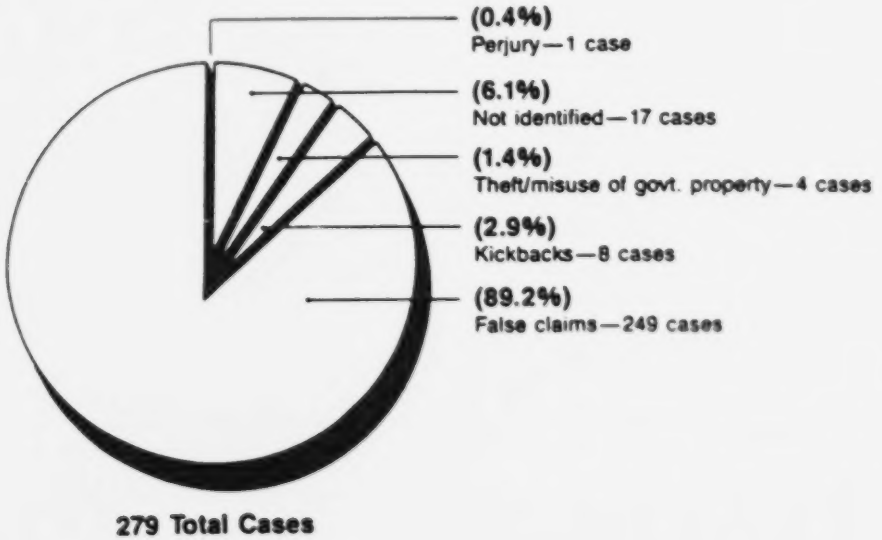
We performed our work at the OIG's headquarters between May and December of 1986. We obtained official oral comments from the IG on June 12, 1987, and included them in this report where appropriate. Our work was performed in accordance with generally accepted government auditing standards.

CHARACTERISTICS OF MEDICARE AND MEDICAID FRAUD CASES REFERRED TO THE DEPARTMENT OF JUSTICE

Using the OIG's fraud classifications, we found that the most prevalent type of health care fraud investigated and referred to Justice for prosecution by the OIG during fiscal years 1984 and 1985 involved false claims, accounting for about 89 percent (249 out of 279) of all cases. The types of false claims involved questionable charges such as billing the Medicare and/or the Medicaid program for (1) services not rendered at all, (2) a more expensive type of service than was actually provided, or (3) services that were provided but not needed.

As shown in figure I.1, other fraud cases included kickbacks (eight cases), theft and/or misuse of government property (four cases), and perjury (one case). The type of alleged illegal activity was not identified for 17 cases in the data base.

Figure I.1: Types of Health Care Fraud Referred to Justice, Fiscal Years 1984 and 1985



Of the 279 cases, 237, or 85 percent, involved investigations of health care providers. As shown in figure I.2, almost half of the providers referred for prosecution were medical doctors. In one of these cases, an anesthesiologist was convicted of submitting over 2,000 fraudulent Medicare claims during a 4-year period. The claims resulted in the Medicare program overpaying the anesthesiologist about $78,000, for actions such as submitting

-- bills for anesthesia services that were not provided or provided by unauthorized subordinates,

-- bills listing more time spent in the operating room administering anesthesia services than hospital records supported, and

-- separate Medicare bills for preoperative and postoperative services provided for the same operation in order to exceed the allowable charges.

About 18 percent of the cases referred for prosecution involved suspected fraudulent activities committed by medical practitioners such as dentists, optometrists, podiatrists, and chiropractors. In one of these cases, an optometrist was convicted of Medicare fraud after submitting 262 fraudulent claims in treating 52 Medicare patients. These claims, totaling almost $33,000, involved billing Medicare for items such as more expensive trifocal glasses when the patient received only bifocal glasses and billing Medicare for contact lenses that were not provided.

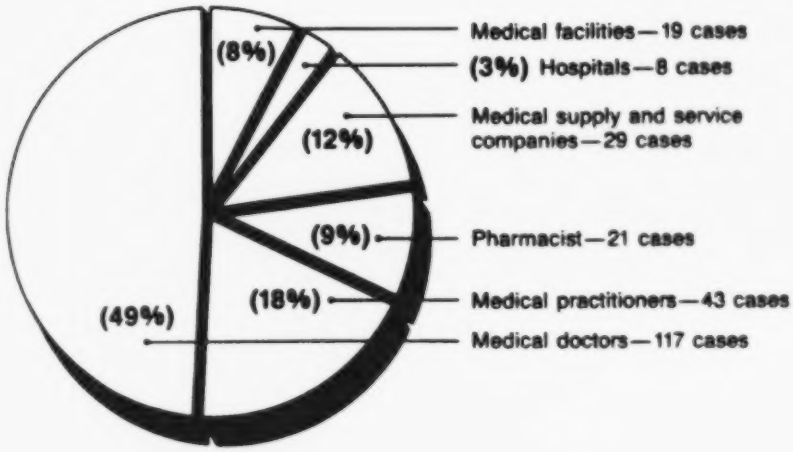
Another 12 percent of the cases involved suspected fraud committed by medical supply and service companies. In one such case, the president and two employees of a medical supply company were convicted of submitting over $80,000 in fraudulent Medicare claims. The OIG investigation revealed that only 52 of the company's 14,000 Medicare claims for syringes and items used to feed patients unable to ingest food orally were legitimate.

Health care facilities such as nursing homes and clinics accounted for another 8 percent of the cases. One of these cases involved a nursing home administrator who submitted Medicaid cost reports containing almost $15,000 for personnel expenses and payments to relatives who did not work the hours claimed.

Pharmacists accounted for about 9 percent of the cases referred to Justice. One of these cases involved a pharmacist who billed Medicaid for higher-priced "name brand" prescription drugs while actually supplying generic drugs to the recipients.

Health care fraud referrals involving hospitals accounted for about 3 percent of the cases. In one such case, a hospital purchasing officer was convicted of mail fraud for embezzling about $74,000 over a 5-year period through the resale to the hospital of items that it had already purchased. These excessive costs resulted in a Medicare/Medicaid overpayment to the hospital totaling about $36,000.

Figure I.2: Types of Health Care Providers Investigated and Referred for Prosecution, Fiscal Years 1984 and 1985

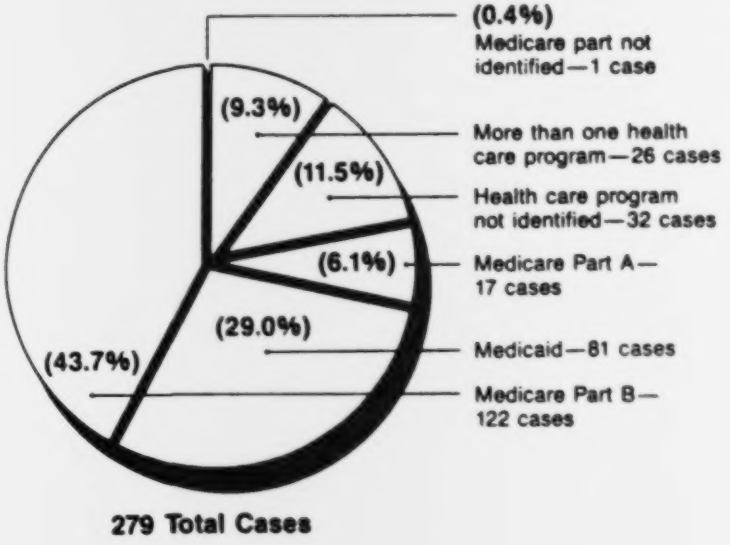


Note: Percentages do not total 100 due to rounding.

Figure I.3 shows the breakdown of the specific health care programs affected by fraud. As shown, 122 of the 279 (about 44 percent) referrals involved the Medicare Part B medical insurance program, while fraud detected in the joint federally and state funded Medicaid program accounted for 29 percent of the cases. About 9 percent of the cases involved suspected fraud detected in more than one health care program.

While we did not evaluate the relative risks of the Medicare and Medicaid programs to fraud, we noted that the Medicare hospital insurance program (Part A) accounted for about 52 percent of the health care funding and about 6 percent of the referred cases. The Deputy Assistant Inspector General for Investigations pointed out that the number of health care providers who participate in the Part B program far exceeds the number of hospitals and other providers that participate in the Part A program. The Assistant Inspector General for Investigations told us that he believed that there was a disproportionately low number of Medicare hospital insurance investigations. He explained that hospital fraud is more difficult to detect and takes longer to develop because it is more difficult to prove. To help ensure the Medicare hospital insurance program's integrity, he has instructed investigators to place greater emphasis on detecting and pursuing Medicare hospital insurance fraud.

Figure I.3: Closed Health Care Fraud Cases Referred to Justice, by Health Care Program, Fiscal Years 1984 and 1985



ACTIONS TAKEN AGAINST THOSE WHO COMMITTED MEDICARE AND MEDICAID FRAUD

According to OIG officials, three types of actions can be taken against health care providers that commit Medicare and/or Medicaid fraud:

-- OIG Civil Monetary Penalties Law action, which includes fines and settlements for fraudulent claims;

-- successful criminal prosecution or civil action obtained by Justice with accompanying prison and/or probation sentences and monetary assessments; and

-- OIG suspension from participation in the Medicare and Medicaid programs.

We found that action was taken against those investigated in 275 of the 351 referrals included in our review. In 89 of the 275 referrals, more than one action was taken against the perpetrator. In total, 389 actions were taken, with CMPL fines and settlements accounting for 150 of the actions; convictions and deferred adjudications[4] accounting for 114 of the actions; agreements between Justice and the subjects before the trial, known as pretrial diversions, in which the subject undergoes a program of supervision or other services without pleading guilty, accounting for 11 cases; and program suspensions accounting for 114 of the actions.

During the course of our review, we identified nine closed cases in which OIG officials decided to initiate a suspension or CMPL action after we brought those cases to their attention. Four of these cases involved providers that were convicted of Medicare and/or Medicaid related violations but were not suspended as required by law. The five other cases involved providers against which no action was taken during our study period. After we questioned the OIG officials as to why CMPL actions had not been taken, they initiated actions against the providers in question.

---

[4]In a deferred adjudication, the court does not enter a guilty judgment on the defendant's plea, but instead places the subject on probation.

Civil Monetary Penalties Law Actions

The Civil Monetary Penalties Law has provided the IG with a means to levy fines and penalties against health care providers that submit false Medicare and Medicaid claims. We found that this authority has been used as both a complement and a supplement to criminal prosecution, in that it has been used to levy fines and penalties and suspend health care providers that were not prosecuted as well as those that had been criminally convicted of Medicare and/or Medicaid fraud from participation in the program.

Provisions of the Civil Monetary Penalties Law

The Civil Monetary Penalties Law was enacted as an amendment to title XI of the Social Security Act by section 2105 of the Omnibus Budget Reconciliation Act of 1981. The CMPL authorizes the Secretary of HHS to impose civil penalties on health care providers that commit fraud against the Medicare and Medicaid programs. One of the Congress's objectives in passing the law was to provide HHS's Secretary a means to punish perpetrators of health care fraud that Justice declined to prosecute because of its work load or because the case involved a small number of claims or a low dollar value.

As required by the CMPL, the Secretary of HHS and the Attorney General have agreed on procedures for the Secretary to initiate a CMPL proceeding. In accordance with a memorandum of understanding between HHS and Justice, the Secretary initiates a CMPL proceeding only after (1) referring the case to Justice for both criminal prosecution and civil action and (2) Justice has either completed its criminal prosecution and/or civil action or declined to take such action.

The CMPL authorizes the Secretary to impose a civil monetary penalty on any person who presents or causes presentation of a Medicare and/or Medicaid claim for which the person knew or had reason to know that the provision of services was not as claimed. This penalty is in addition to any other penalty that may be prescribed by law. The penalties authorized by the CMPL include

-- a penalty of not more than $2,000 for each item or service (42 U.S.C. 1320a-7a(a)),

-- an assessment of not more than twice the amount claimed for each such item or service in lieu of damages sustained (42 U.S.C. 1320a-7a(a)), and

-- a program suspension (42 U.S.C. 1320a-7(c)).

To protect an individual's right to due process, the law and/or implementing regulations require that prior to the Secretary's making a determination that would adversely affect an individual, that individual

-- shall be given written notice of the intended penalties;

-- may request a hearing before an administrative law judge (During this hearing, the provider has the right to be represented by counsel and to cross-examine all witnesses.); and

-- may appeal penalties and assessments to the U.S. Court of Appeals and suspensions to the U.S. District Court.

Furthermore, in determining the amount or scope of any civil monetary penalties, the Secretary shall take into account (1) the nature of claims and the circumstances under which they were presented, (2) the degree of culpability, history of prior offenses, and financial condition of the persons presenting the claims, (3) and other matters as justice may require.

Under HHS regulations implementing the CMPL, the Secretary delegates much of his authority to the IG. These regulations permit the IG to negotiate a settlement agreement with health care providers prior to a final decision by the Secretary. The IG may use a settlement agreement in lieu of proceeding with a CMPL action. Typically, settlement agreements contain the following information:

-- the parties to the settlement agreement--that is, the provider and the IG;

-- a description of the provider's participation in the Medicare and/or Medicaid program;

-- the intention of the provider and the IG to reach a settlement and avoid the uncertainty and expense of litigation;

-- a schedule of payments, if installment payments are agreed to;

-- a release by the IG of any claims it might have against the provider under the CMPL in consideration of monetary settlement; and

-- a statement that the agreement will not be considered as an admission of liability or wrongdoing on the part of the provider.

Civil Monetary Penalties Law
Fines and Penalties

We found that 150 of the 199 cases that were considered for CMPL action during fiscal years 1984 and 1985 resulted in a monetary fine or settlement. Thirty-nine percent of the fines and settlements involved health care providers previously convicted of Medicare and/or Medicaid fraud, and 61 percent involved providers that Justice declined to prosecute. Moreover, 11 providers that Justice declined to prosecute were suspended using CMPL authorities.

CMPL fines and settlements during fiscal years 1984 and 1985 totaled about $17 million. Based on our review of the case files containing overpayment data, we found that the CMPL fines and settlements resulted in potential recoveries of almost $3.50 for every $1.00 that had allegedly been overpaid. As shown in table I.1, about 41 percent of the CMPL cases resulted in settlements and fines of more than $50,000. Four cases had fines or settlements of $1 million or more. We also found that the CMPL cases, for which data were available, involved overpayments of claims ranging from $66 to $550,000. As shown in table I.2, the majority of CMPL cases, for which data were available, involved alleged overpayments of amounts under $10,000.

Table I.1: Civil Monetary Penalties Law Fines and Settlements, Fiscal Years 1984 and 1985

Fines or settlement amount	Number	Percentage of all fines or settlements
Less than $10,000	23	15
$10,000 to $24,999	32	21
$25,000 to $49,999	34	23
$50,000 to $99,999	21	14
$100,000 to $499,999	33	22
$500,000 to $999,999	3	2
$1,000,000 or more	4	3
Total	150	100

Table I.2: Fraudulent Overpayments Made in Cases Using the Civil Monetary Penalties Law, Fiscal Years 1984 and 1985

Amount of overpayment	Number of perpetrators	Percentage of perpetrators
Less than $1,000	18	16
$1,000 to $9,999	51	44
$10,000 to $49,999	26	23
$50,000 to $99,999	11	9
$100,000 or more	9	8
Total	115[a]	100

[a]OIG case files contained information about overpayments for 115 of the 150 cases in which CMPL action was taken.

We found that in almost all of the CMPL cases in which action was taken (147 out of 150), the IG and the provider negotiated a settlement concerning the alleged fraudulent activities in lieu of completing a formal proceeding. OIG and HHS Office of General Counsel officials told us they prefer using settlement agreements to resolve CMPL proceedings. They pointed out that they can reach settlement agreements more quickly than they can conduct formal proceedings leading to the imposition of a fine. They also pointed out, and we verified, that during fiscal years 1984 and 1985, settlement agreements were successful in recovering more than three times the amount believed to have been fraudulently obtained. We found that for fiscal years 1984 and 1985, the 147 settlement agreements[5] accounted for about $14.6 million of the $17 million generated by CMPL enforcement.

The OIG's largest reported fine or settlement was with a chiropractor and his wife who were ordered to pay about $1.8 million as a result of submitting over 2,700 false claims and receiving about $25,000 in overpayments. The subject in this proceeding appealed this decision to the U.S. Court of Appeals for the Eleventh Circuit, questioning such things as the constitutionality of the law and the severity of the fine imposed. The court ruled in favor of HHS, stating that the law is constitutional and the fines were appropriate, considering the actions of the subject. According to court records, the subject engaged in an elaborate scheme of hiring foreign physicians who had little knowledge of the English language to sign Medicare claims for the sole purpose of legitimizing chiropractic services that otherwise would not have been allowed. In upholding the civil penalties imposed by an administrative law judge, the court pointed out that the subject also attempted to deceive investigators by fabricating documents during the course of the investigation.

The smallest reported CMPL fine or settlement was with a pharmacist who agreed to pay a $2,000 civil monetary penalty as a result of overpayments totaling about $10,790. The subject in this case had previously been convicted by a state court and ordered to make restitution of the overpayments.

---

[5]In some settlement agreements, the provider agrees to a program suspension, while other agreements provide that no action other than the CMPL fines, including suspension, will be taken against the provider on claims covered by the agreement.

The Inspector General's Use of the Civil Monetary Penalties Law in Conjunction With Other Actions

We found that the IG utilized the CMPL authorities, in addition to other types of actions, in 70 of the 150 cases (about 47 percent) whose subjects were assessed a fine or settlement during fiscal years 1984 and 1985. The subjects in the remaining 80 cases were assessed with CMPL monetary penalties without any additional action being taken. As shown in figure I.4,

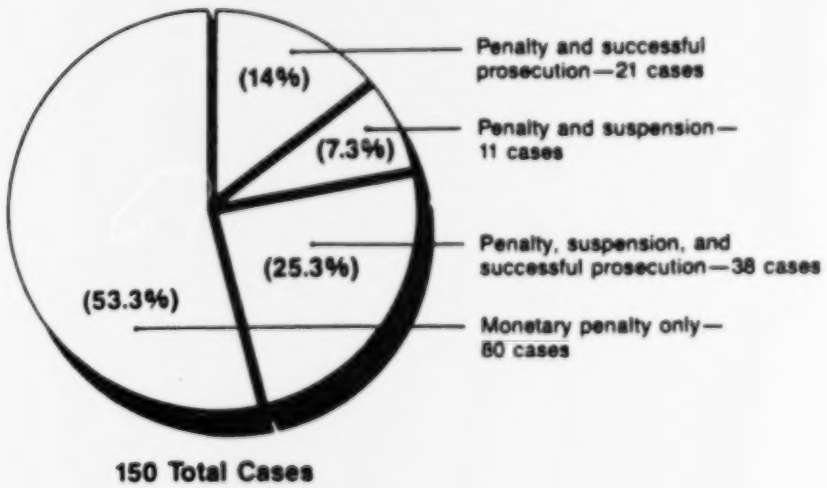
-- subjects in 80 cases were assessed with CMPL monetary penalties only;

-- subjects in 38 cases were successfully prosecuted, assessed with a civil monetary fine or settlement, and suspended from the Medicare and Medicaid programs;

-- subjects in 21 cases were successfully prosecuted and assessed with a civil monetary fine or settlement; and

-- subjects in 11 cases were not prosecuted but were assessed with a civil monetary fine or settlement and suspended from the Medicare and Medicaid programs.

Figure I.4: Civil Monetary Penalties Law Cases, Types of Actions Taken, Fiscal Years 1984 and 1985



Note: Percentages do not total 100 due to rounding.

The following are three examples of providers who were convicted, assessed with civil monetary penalties, and suspended from the Medicare and Medicaid programs. In the first case, a physician pled guilty for himself and his professional medical corporation to submitting false Medicare claims over a 3-year period. The court ordered him and his corporation to pay $50,000 in criminal fines and $23,000 in restitution. The court also sentenced him to 3 years in jail, 2 years and 10 months of which was suspended. Subsequently, the physician agreed to pay a $288,500 civil monetary penalty. In addition, the IG suspended the physician from participating in the Medicare and Medicaid programs for 3 years.

In the second example, a nursing home administrator who pled guilty to submitting $14,598 in false Medicaid claims was sentenced to 30 days in jail. In addition, he agreed to pay a civil monetary penalty of $29,196, and the IG suspended him from the Medicare and Medicaid program for 5 years.

In the third example, an anesthesiologist pled guilty for himself and his professional medical corporation to submitting false Medicare claims totaling about $1,200. The court fined him a total of $26,000. In addition, the anesthesiologist agreed to pay a civil monetary penalty of about $45,000, and the IG suspended him from the Medicare and Medicaid program for 2 years.

Civil Monetary Penalties
Law Collections

We reviewed the department's CMPL collection process and found that subjects in 142 of the 150 cases had either paid the agreed upon amount or were making the scheduled installment payments. The total value of the eight cases in which the fines/agreements are in arrears was about $1 million. One of these cases involves a provider that is currently awaiting a decision by the U.S. Court of Appeals on an appeal of a $150,000 CMPL fine. According to the OIG records, HHS declared the other seven providers in default, and, at the time of our audit, had obtained a judgment against one of the seven providers concerning the defaulted amount.

Another case whose subject was in default was sent to Justice in May 1985. The case involved a chiropractor who was ordered to pay a civil monetary penalty of about $468,000 for submitting about 500 false Medicare claims totaling about $14,000. When we contacted Justice officials concerning that judgment, they said that due to staff turnover in the Judgment Enforcement Unit, they overlooked the case. We were subsequently told that the provider is a fugitive and that efforts are underway to find him so that Justice can secure and collect a judgment. The remaining five

cases in default were sent to Justice for action during fiscal year 1986.

Prosecutive Actions

According to the OIG case files, 114 health care fraud cases during fiscal years 1984 and 1985 resulted in either a conviction or deferred adjudication. Another 11 health care cases resulted in pretrial diversions, which are agreements between the prosecutor and a subject that diverts the subject from a traditional criminal justice proceeding to a program of supervision or other services. If the subject successfully completes the established requirements, prosecution is declined and no criminal record is established. However, if the offender does not successfully comply with the requirements, prosecution can be initiated.

Prison and Probation Sentences

Of the 114 cases resulting in either a conviction or deferred adjudication, OIG records showed whether or not a sentence had been levied against the subjects in 101 cases. According to OIG records, the subjects in 11 of these cases were not sentenced to either prison or probation. The remaining 90 subjects were sentenced as follows:

-- 38 subjects received both prison and probation terms,

-- 18 subjects received prison terms only, and

-- 34 subjects received probation only.

In total, 56 of the 101 subjects received prison terms. As shown in table I.3, these prison sentences ranged from 6 days to 6 years. About 41 percent of the sentences were for less than 2 years. Of the subjects who received prison sentences, 72 percent received sentences of less than 4 years.

Table I.3: Health Care Fraud Prison Sentences, Fiscal Years 1984 and 1985

Length of sentence	Number convicted with prison sentences	Percentage of prison sentences
At least 6 days but less than 6 months	6	11
At least 6 months but less than 1 year	4	7
At least 1 year but less than 2 years	13	23
At least 2 years but less than 3 years	7	13
At least 3 years but less than 4 years	10	18
At least 4 years but less than 5 years	3	5
At least 5 years but less than 6 years	11	20
6 years	2	4
Total	56	101[a]

[a]Does not equal 100 because of rounding.

As shown in table I.4, almost half of the 56 who were convicted had some of their prison sentence suspended. Forty-five percent of those convicted and sentenced to prison had at least half of their sentence suspended, and 27 percent had all of their sentence suspended.

Table I.4: Health Care Fraud: Percent of Prison Sentences Suspended, Fiscal Years 1984 and 1985

Percent of sentence suspended	Number of prison sentences	Percentage of prison sentences
0	29	51
17 to 49	2	4
50 to 69	3	5
70 to 79	1	2
80 to 89	2	4
90 to 99	4	7
100	15	27
Total	56	100

A total of 72 of the convicted subjects were sentenced to probation. As shown in table I.5, these sentences ranged from 85 days to 7 years on probation. About 61 percent of the sentences were for at least 2 years but less than 4 years.

Table I.5: Health Care Fraud Probation Sentences, Fiscal Years 1984 and 1985

Length of probation	Number of subjects convicted and sentenced to probation	Percentage of probation sentences
At least 85 days but less than 1 year	1	1
At least 1 year but less than 2 years	5	7
At least 2 years but less than 3 years	21	29
At least 3 years but less than 4 years	23	32
At least 4 years but less than 5 years	4	6
At least 5 years but less than 6 years	16	22
At least 6 years but less than 7 years	0	0
7 years	2	3
Total	72	100

Pretrial Diversion Agreements

For the 11 cases in which a prosecutor and a subject agreed to pretrial diversions, the subjects were placed in a program of supervision for a specified period, with the understanding that the subject must adhere to the terms of the agreement or face prosecution. In the pretrial diversions that were available for review at the OIG's headquarters, the subjects signed agreements in which they pledged to

-- abide by the law;

-- work regularly at a lawful occupation;

-- continue to live in their judicial district;

-- report to their program supervisor as directed;

-- follow all directions of their program supervisor, including the performance of community work; and

-- submit only truthful, accurate, and proper claims to all medical insurance programs, whether the program is operated by the government or private industry.

Fines, Restitutions, and Recoveries

Of the 114 convictions and deferred adjudications and 11 pretrial diversions, there were 80 cases in which a monetary assessment had been imposed as part of the outcome of Justice's actions. The individuals in these 80 cases were ordered to pay a total of almost $1.8 million in monetary assessments.

We found that the monetary assessments ranged from $100 to $262,000. As shown in table I.6, 51 percent of the subjects received monetary assessments of less than $10,000, and 75 percent had a monetary assessment of less than $25,000. We did not determine whether these assessments were actually collected.

Table I.6: Monetary Assessments on Health Care Cases Accepted for Prosecution, Fiscal Years 1984 and 1985

Dollar ranges	Number of subjects with monetary assessments[a]	Percentage of monetary assessments
Less than $10,000	41	51
$10,000 to $24,999	19	24
$25,000 to $49,999	13	16
$50,000 to $99,999	4	5
$100,000 to $199,999	1	1
$200,000 or more	2	3
Total	80	100

[a]Monetary assessments include fines, restitutions, and recoveries.

Program Suspensions of Providers Referred to Justice

The Social Security Act requires the suspension of health care providers convicted of Medicare and/or Medicaid program-related violations from participation in these programs. The Social Security Act also allows the Secretary to suspend from the Medicare program providers that knowingly or willfully (1) make or cause to be made any false statements, (2) provide poor-quality services, or (3) provide excessive services. In addition, as a result of the CMPL amendment to the Social Security Act, the Secretary can suspend from the Medicare and Medicaid program providers that present, or cause to present, a claim for medical or other service that the claimant knows or had reason to know was not provided as claimed.

Of the 114 health care convictions and deferred adjudications and the 11 health care pretrial diversions, we found that the OIG suspended the subjects in all but 13 of the 90 cases that were eligible for a program suspension. As for subjects in the remaining 35 cases, we found that they were not eligible for a program suspension because they were either not providers or their conviction was not based on the submission of Medicare and/or Medicaid claims--even though they were investigated for Medicare and/or Medicaid fraud.

Our examination of the 13 providers that the IG was authorized to suspend from the Medicare and/or Medicaid program but did not, showed that

-- four providers had actually been convicted,

-- four providers received deferred adjudication, and

-- five providers entered into pretrial diversions.

After we asked why the four convicted providers had not been suspended as required, OIG officials told us they overlooked these cases and would initiate suspension actions on them. Of these four convictions, two occurred in 1983 and the other two took place in 1985. Thus, in these four cases, convicted providers were afforded the opportunity to continue submitting claims. In one of these cases, a provider had been convicted in December 1983 of fraudulently obtaining about $120,000 in Medicare and Medicaid payments. While our review was ongoing, the OIG's Director, Health Care Administrative Sanctions Branch, informed us that the OIG has implemented a new procedure to help prevent future oversights. The new procedure requires that a high-level IG official review all cases before they are closed to ensure that all appropriate actions

have been taken. We believe that a thorough high-level review of all cases prior to their closure will help prevent such oversights. We plan to monitor the OIG's new procedure during our ongoing quality assessment review, which is designed primarily to evaluate whether OIG audits and investigations satisfactorily comply with professional standards.

As for the remaining nine providers (four who received deferred adjudications and five who entered into pretrial diversions), senior OIG and HHS Office of General Counsel officials told us that the IG is not required to suspend providers in such cases. They told us that the law mandates the suspension of providers actually convicted of program-related crimes--not of providers that agreed to deferred adjudications or pretrial diversions. We found that although the law does not mandate the suspension of these providers, HHS has the authority to do so because these providers admitted submitting false statements or claims either before a judge or in their pretrial diversion agreements. Three of the nine providers submitted false Medicare claims. Section 1862 (d) of the Social Security Act, 42 U.S.C. . 1395 y (d), authorizes the Secretary to suspend providers who "knowingly and willfully made or caused to be made, any false [Medicare] statements."

In one of these cases regarding Medicare claims, a physician received about $27,000 from the Medicare program for operating an exercise club on behalf of senior citizens. According to IG records, the physician billed Medicare for individual medical services but actually conducted general group exercises and provided group lectures. The physician was able to defraud the Medicare program by having recipients sign blank receipts which were later completed and submitted to Medicare for payment. As a result of the investigation, the physician entered into a pretrial diversion on July 1, 1983, requiring, among other things, restitution in the amount of about $23,000. The physician did not pay a civil monetary penalty, and the IG did not suspend the physician from the Medicare or Medicaid programs.

The remaining six providers submitted false Medicaid claims. Section 1128 (c) of the Social Security Act, 42 U.S.C. 1320a-7 (c), authorizes the Secretary to suspend providers who "present or causes to present . . . a claim [Medicare or Medicaid] . . . that the person knows or had reason to know was not provided as claimed" whenever the Secretary makes a final determination to impose a CMPL monetary penalty. In one of these six cases, a nursing home administrator was found to have defrauded the Medicaid program of about $15,000 between February 1982 and March 1984. In October 1984, the administrator entered into a pretrial diversion agreement in which he admitted filing false cost reports. Not only

was he not suspended from participating in the Medicaid or Medicare programs, but he was also not required to repay the money he fraudulently obtained, nor pay any fines or civil money penalties. We found that this individual subsequently moved to another state and was later convicted of Medicaid fraud while employed as an administrator of another nursing home and was fined $1,550.

When we discussed these cases with the Deputy Assistant Inspector General for Investigations, she was unable to provide specific reasons why suspension actions were not taken because of the age of the cases. She did indicate that at the time the OIG considered these cases, each region independently determined the necessary action without OIG headquarters oversight. She pointed out that a high-level headquarters OIG official now reviews these types of decisions, to ensure appropriate actions are being taken. As previously discussed, we believe that a thorough high-level review of all cases prior to their closure will help prevent any oversights.

Cases in Which No Action Was Taken

Of the 351 cases reviewed, we found that action was not taken against the subjects in 73 cases during our study period, and the OIG's data base did not identify whether or not an action was taken on the subjects in 3 cases. According to OIG records, it considered 56 cases to lack prosecutive merit, closed 5 cases because they involved low dollar amounts, closed 2 cases after Justice decided the subjects could not be found, and closed 1 case after the charges were dropped. The remaining nine cases were pending CMPL action.

To determine the reasons why the OIG closed cases for lack of prosecutive merit, we judgmentally selected 30 of the 56 cases for review. We found that the primary reasons they lacked merit included the following:

-- allegations against the subject could not be substantiated,

-- the subject appeared to make honest mistakes in completing Medicare claim forms, and

-- program guidance was too ambiguous to show any intent to defraud.

As for the nine cases that are pending a CMPL action, we found that the OIG initiated five of the actions after we inquired why

such action had not been taken. One of the five cases had been returned to OIG investigators for further work, even though the case was classified as closed. However, the files did not show that any action had been taken on the case in the 16 months since it was returned to the investigators. After we inquired about the status of the case, the provider was suspended from the Medicare and Medicaid program, and CMPL action was taken.

INSPECTOR GENERAL EFFORTS TO DETERMINE THE UNDERLYING CAUSES OF MEDICARE AND MEDICAID FRAUD AND RECOMMEND CORRECTIVE ACTION

The IG established the Management Implication Report (MIR) system to help strengthen the integrity of HHS programs by attempting to prevent fraud and abuse. The MIR system requires investigators to identify program vulnerabilities during criminal investigations and provide recommendations to managers to correct these deficiencies. However, we found that often there was no assurance that vulnerabilities had been communicated to program managers so that underlying causes of fraud could be corrected and future occurrences prevented. Contrary to written requirements, the OIG's Office of Analysis and Inspection (OAI), which is responsible for determining the validity of MIRs and transmitting valid ones to program managers, often did not document whether valid health care MIRs were transmitted nor record adequate rationale for not transmitting MIRs. In addition, in those instances where further study or analysis was deemed necessary to determine the validity of the MIR, the OAI often did not document whether the action was carried out.

The OIG's Investigator's Handbook indicates that investigators should prepare a MIR when, during the course of a fraud investigation, they find that a policy, procedure, or systems process fails to prevent, detect, or minimize losses due to fraud, waste, or abuse. When they uncover such weaknesses, investigators are required to develop a MIR that includes such items as a description of the program, summaries of the violation and the system or procedural weakness that allowed or contributed to the fraud, and a recommendation to correct the deficiency directed to appropriate program managers. Within the OIG's Office of Investigations, the head of the field investigative office and a headquarters unit specializing in health care programs review and approve MIRs to ensure that the reports are clear and valid and contain all necessary information. In addition, within the Office of Investigations, a program inspector knowledgeable about health care programs further reviews approved MIRs and has the responsibility for incorporating additional information on similar problems or recommendations previously made.

Once the Office of Investigations approves a MIR, and adds other pertinent information, it then transmits the MIR to the Health Care Branch of the Program Inspection Division within the OIG's Office of Analysis and Inspection. The branch maintains a log that identifies the status of each MIR and provides the branch with the ability to individually and collectively analyze MIRs. The branch assigns MIRs to its analysts, who are responsible for contacting the appropriate program manager regarding the identified vulnerability and further validating the MIR. The analysts then determine the disposition of the MIR by determining that either no additional action is necessary or that one of the following types of action should be taken: (1) the vulnerability should be addressed in a further IG review, (2) a fraud alert should be issued, or (3) a recommendation should be made to program managers. Analysts are required to provide a brief rationale supporting any determination. The branch is also responsible for following up on recommendations to ensure that appropriate action has been taken.

The following are two examples of MIRs reported by investigators during fiscal years 1984 and 1985. In the first case, an acting regional inspector general for investigations submitted a MIR in March 1984 stating that anesthesiologists can and have billed Medicare and Medicaid for approximately twice the anesthesia time actually provided. The MIR pointed out that because anesthesiologists are paid for time spent in the operating room but are not required to submit hospital records documenting their actual time there, they can easily overcharge for such time. The MIR identified three anesthesiologists who in 1984 agreed to pay CMPL settlements totaling $140,000 for submitting Medicare and Medicaid claims for anesthesia with inflated time charges. To help prevent this type of fraud, the MIR included a recommendation that anesthesiologists be required to submit copies of hospital records that document the time spent administering anesthesia in the operating room.

In the second example, a regional inspector general for investigations submitted a MIR in July 1985, which pointed out that because of Medicare's multiple billing methods, two doctors could--and did successfully--bill Medicare for providing renal dialysis to the same patient at the same facility for the same period. The MIR included a recommendation that Medicare establish a control that would check for such multiple billings.

During 1984 and 1985, the Office of Investigations transmitted 99 MIRs to the Office of Analysis and Inspections. We tried to determine the disposition of these MIRs, but OAI officials told us that they did not have a tracking system and could not readily provide the status of health care MIRs.

We reviewed the 99 MIRs and related documents and found that the Office of Investigations approved 78 MIRs that identified program vulnerabilities to fraud, waste, and abuse. We found some evidence in the files that program managers were contacted regarding the vulnerabilities in 35 of the MIRs. When questioned about the remaining 43 MIRs (about 55 percent), OAI officials could not tell us whether the vulnerabilities had been communicated to the program managers.

Our examination of the files for these 43 MIRs showed that an OAI analyst concluded that no additional action would be taken for 23; some action was deemed necessary for 18. There was no information in the file as to what was decided for the other two MIRs. For the 23 in which no action was to be taken, the justification required by the regulations was often not provided or was contradictory in nature. For 18 MIRs where some action was deemed necessary, there was no documentation to determine whether actions such as further study or the issuance of a fraud alert to program managers were taken. For seven of these MIRs, an OAI analyst recommended the establishment of a fraud alert; however, our review of the fraud alert files showed that they were never issued.

When we discussed the adequacy of the MIR system with the Assistant Inspector General for Investigations, he indicated that he was aware that MIRs prepared by the investigators are not always transmitted to program managers so that corrective action can be taken. He told us that because the vulnerabilities are not being transmitted to program managers, it is difficult to motivate investigators to carry out their responsibility to prepare MIRs. In this regard, while our review was ongoing, his office sent a memorandum to the heads of the field investigative units reemphasizing the importance of the MIR program. The memorandum pointed out that his office had recently completed a review of the MIR program and found that the rate at which field investigators were submitting MIRs had dropped significantly.

When we discussed the adequacy of the MIR system with the Deputy Assistant Inspector General for Analysis and Inspection, he acknowledged that the Health Care Branch had not been effective in notifying health care program managers of vulnerabilities reported in MIRs. He told us that the Health Care Branch is implementing new procedures to ensure that it communicates these vulnerabilities so that the underlying causes of fraud can be corrected. According to draft instructions, the new procedures include instituting a system to track all MIRs received by the branch and assigning the responsibility for ensuring that the appropriate actions are taken and documented regarding the disposition of all health care MIRs to a specific individual. We were also told that analysts will now be

required to document all contacts made with program managers. We plan to review this system in more detail during our OIG Quality Assessment Review and determine the need, if any, for additional action.

(911589)

Requests for copies of GAO reports should be sent to:

U.S. General Accounting Office
Post Office Box 6015
Gaithersburg, Maryland 20877

Telephone 202-275-6241

The first five copies of each report are free. Additional copies are $2.00 each.

There is a 25% discount on orders for 100 or more copies mailed to a single address.

Orders must be prepaid by cash or by check or money order made out to the Superintendent of Documents.